

Division of Health Care Facilities

45th 8/03/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/19/2013
NAME OF PROVIDER OR SUPPLIER BRADLEY HEALTH CARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312		
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N 000	Initial Comments Based on results of an annual Licensure survey conducted on June 10, 2013, through June 19, 2013 the facility was cited a type "A" penalty for failure to be administered in a manner to ensure supervision was provided for a safe environment to prevent accidents, for failure to ensure the Medical Director provided oversight and participation in the development of policies and procedures to ensure an effective system for supervision of residents at risk for falls, and for failure of the facility Quality Assurance Committee to identify resident falls as areas for quality improvement. The facility's failure placed residents #134, #37, #58, and #71 in an environment which was detrimental to their health, safety and welfare. The facility's systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place residents #95, #111, #52, #193, #2, and #18 (of fifty-six residents reviewed) in an environment which was detrimental to their health, safety and welfare.	N 000			
N 424	1200-8-6-.04(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Based on medical record review, review of facility	N 424	Resident # 134, # 37, #58, #71, #95, #111, #52, #193, #2, #18 and #13 1. # 134 Treatment plan and falls interventions were reviewed by DON, ADON, and MDS Coordinator on 6/20/13, noting clarifications to interventions on 6/19/13 being fall mats next to bed (not PRN) and on 6/24/13 clarification of assist up for meals and offer assistance to Dining Room as tolerated (resident refuses at	07/15/13	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

STATE FORM

6899

32HM11

If continuation sheet 1 of 44

JUL 22 2013

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N 424	<p>Continued From page 1</p> <p>fall investigation documentation, interview, review of manufacturer's recommendations, observations, review of facility restraint committee meeting minutes and review of the facility policy for Sunshine Room Guidelines, the facility failed to be administered in a manner to provide supervision to prevent multiple falls for four residents #134, #37, #58 and #71, placing the residents in an environment which was detrimental to their health, safety, and welfare.</p> <p>The facility's systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place residents #95, #111, #52, #193, #2, and #18 (of fifty-six residents reviewed) at risk for falls in an environment which was detrimental to their health, safety, and welfare.</p> <p>The findings included:</p> <p>Resident #134 was admitted to the facility on June 17, 2009, and readmitted on August 17, 2012, with diagnoses of Fractured Femur, Anxiety, Depression, Difficulty in Walking, Senile Delusion, and Personal History of Falls.</p> <p>Medical record review of a Significant Change Assessment dated July 10, 2012, revealed the resident had severely impaired cognition; behaviors placed the resident at significant risk for injury; required extensive assistance with transfers and toilet use; balance not steady, only able to stabilize with staff assistance during transition and walking; and had two falls with injury since the previous assessment on April 2, 2012.</p>	N 424	<p>times), resident fed by staff in room as needed. Fall Interventions for this resident are: Low bed in low position and wheels locked, fall mats beside bed, soft belt restraint in w/c, up for meals as tolerated, bed alarm. Resident care plan was reviewed on 6/19/13 by MDS Coordinator and DON assessed resident care plan and spoke with resident on 6/20/13. Resident was in w/c with no distress noted. Medical Director reviewed treatment plan, including falls interventions and reaffirmed plan of care on 6/25/13. Direct care staff was in-serviced on intervention changes on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance – random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/19/13 ensuring proper devices were in place and operational (low bed, floor mat, bed alarm).</p>		

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N 424	<p>Continued From page 2</p> <p>Medical record review of the Care Plan originally dated September 15, 2011, revealed, "...Falls...Falls will be avoided and safety will be maintained...will not sustain serious injury if fall occurs...bed should be in a low position with wheels locked...Check environment for fall risk factors and take corrective action as needed...wears nonskid shoes...May use personal alarms. Chair pad alarm..." Further review of the Care Plan revealed updates as follows: "...11/4/11 make positive chair alarm is in contact c (with) res (resident's) clothing & (and) operational. 11/9/11 add alarming seat belt to recliner along c chair pad alarm & alarming seat belt to w/c (wheelchair)...2/19/12 q (every) 15 min (minute) visual (checks) while in w/c during 11p-7a (11:00 p.m. to 7:00 a.m.)...2/20/12 psych (psychiatric) NP (Nurse Practitioner) d/t (due to) (increased) confusion/agitation...5/5/12 inst (instruct) res to use call light before getting (up)..."</p> <p>Medical record review of a Nurse's Note dated June 11, 2012, at 4:00 p.m., revealed, "At aprox (approximately) 1:15 CNA (Certified Nursing Assistant) called nurse into room...Resident noted laying on (R) (right) side on floor in front of recliner. Head on floor...Resident has a large knot to (R) side of head above ear...Send resident to ER (Emergency Room)..." Further review of the Nurse's Note revealed the resident was sent back to the facility with no fractures noted and no new orders.</p> <p>Review of a fall investigation dated June 11, 2012, revealed, "...safety device in place prior to fall alarming chair pad et (and) alarming seat belt...chair pad alarm et seat belt alarm sounding..."</p>	N 424	#37 Treatment plan and falls interventions were reviewed by DON, ADON, and MDS Coordinator on 6/20/13, with changes to care plan being anti-tippers to w/c on 6/24/13. Fall interventions for this resident are: bed against wall, floor mat, anti-tippers on w/c, soft belt in w/c, and chair alarm in room. DON assessed resident and care plan on 6/24/13. Changes/updates made to care plan, resident in w/c with soft belt applied. Medical Director reviewed treatment plan, including falls interventions and reaffirmed plan of care on 6/25/13. Direct care staff was in-serviced by Clinical Manager on 6/24/13 and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/19/13 ensuring proper devices were in place and operational (floor mat, anti-tippers on w/c, soft belt and chair alarm).		

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N 424	<p>Continued From page 3</p> <p>Review of the fall investigation 72 Hour Follow-up dated June 14, 2012, revealed, "...S.S. (Social Service) to request family meeting to discuss alarms and interventions..."</p> <p>Interview with the Director of Nursing (DON) on June 12, 2013, at 10:09 a.m., in the conference room, confirmed the facility failed to request and conduct a family meeting and no other new interventions were put in place.</p> <p>Medical record review of a Nurse's Note dated July 1, 2012, at 10:00 a.m., revealed, "...heard a alarm and I went running down the hall...when I entered the room I found (resident) sitting in...recliner with...seatbelt unhooked and pt (patient) was sitting on...leg rest of...extended recliner and pt body was still sitting in the recliner chair...instructed the pt to press call light before getting up..."</p> <p>Review of a facility fall investigation dated July 1, 2012, revealed "...heard alarm...found resident sitting on the end of the recliner on the foot rest...resident's mental status before incident disoriented..."</p> <p>Medical record review of the Falls Prevention Program Interventions (form on which a record of the resident's falls was documented) dated July 1, 2012, revealed, "...inst (instructed) to use call light. Placed on list for psych (interventions which were already on the Care Plan May 5, 2012, and February 20, 2012, respectively)..."</p> <p>Review of the fall investigation 72 hour Follow-Up dated July 4, 2012 (for the incident on July 1, 2012), revealed, "...Instructed Resident on use of call light. Placed on list for psych..."</p>	N 424	<p>#58</p> <p>Treatment plan and falls interventions were reviewed by DON, ADON, and MDS Coordinator on 6/20/13, with changes to care plan on 6/24/13. DC 1:1, fall interventions for this resident are nonskid footwear, weighted blanket, sunshine room during hours of operation when up in w/c and wife or daughter not present, bed and chair alarm. Resident care plan was reviewed and resident assessed on 6/20/13 by DON with no changes at that time. Resident was in sunshine room at the time (approximately 11am). Clarification of intervention on 6/24/13 added "when daughter not present" and bed/chair alarm, eliminating verbage "when indicated". Resident care plan was reviewed by MDS Coordinator on 6/24/13. Medical Director reviewed treatment plan, including falls interventions and reaffirmed plan of care on 6/25/13. Direct care staff was in-serviced on 6/18/13 by Clinical Manager regarding sunshine room attendance and taking resident there when up. Direct care staff was in-serviced by Clinical Manager on 6/24/13 and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/ Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical</p>		

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N 424	<p>Continued From page 4</p> <p>Medical record review of a Nurse's Note dated July 2, 2012, at 3:45 p.m., revealed, "...Pt (patient) was witnessed falling on floor...CNA...heard alarm so...went to see and saw pt standing up in front of...w/c try to turn off...w/c alarm. Pt looked at CNA and fell and hit...head on bedside table and buttocks on floor...Redness observed to (L) (left) midback..."</p> <p>Review of a facility fall investigation dated July 2, 2012, revealed "alarm sounding...pt was standing up in front of w/c (wheelchair) trying to turn alarm off...resident's mental status before incident disoriented..."</p> <p>Medical record review of the Care Plan updated on July 2, 2012, revealed "...enc (encourage) to use call light."</p> <p>Review of the fall investigation 72 Hour Follow-Up dated July 5, 2012 (for the fall on July 2, 2012), revealed, "...Red area to (L) posterior thoracic. Encouraged to use call light. Request M.D. (physician) work (up)..."</p> <p>Interview with the Director of Nursing (DON) on June 12, 2013, at 10:09 a.m., in the conference room, confirmed the resident had been disoriented at the time of the incident and encouraging the resident to use the call light had not been an appropriate intervention.</p> <p>Medical record review of a Physical Therapy Screening Tool dated July 2, 2012, revealed, "Pt fell 7/1 from recliner trying to transfer...self & 7/2/12...stood up from...w/c p (after) removing...seatbelt alarm & turned to refasten...seatbelt & fell. Just got off antibiotics 6/30/12 for UTI (Urinary Tract Infection).</p>	N 424	<p>Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/19/13 ensuring proper devices were in place and operational (bed alarm and chair alarm).</p> <p>#71</p> <p>Treatment plan and falls interventions were reviewed by DON, ADON, and MDS Coordinator on 6/20/13 with clarifications of bed against the wall and low bed. Fall interventions for this resident are: bed against wall, low bed, floor mat, bed alarm, nonskid footwear, and soft belt while in w/c. DON assessed resident, restraint was in place and no distress noted, and reviewed care plan on 6/20/13. Medical Director reviewed treatment plan, including falls interventions and reaffirmed plan of care on 6/25/13. Direct care staff was in-serviced on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/20/13 ensuring proper devices were in place and operational (low bed, floor mat, bed alarm).</p>		

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N 424	<p>Continued From page 5</p> <p>Recommend medical work up prior to beginning PT (physical therapy) rescreen...Rescreen PRN (as needed)..."</p> <p>Medical record review of a Nurse's Note dated July 3, 2012, at 3:00 p.m., revealed, "...At aprox 12:15 pm this nurse was called to resident's room. CNA c resident. Resident observed sitting on floor, c back against hand rail, on (resident's) bottom in bathroom floor...0 (no) injuries noted..."</p> <p>Review of a facility fall investigation dated July 3, 2012, revealed "...resident was found sitting on floor in bathroom...resident turned chair alarm off...Safety Device in place prior to fall alarming seat belt...resident trying to transfer self to toilet...q 15 min x 3 hrs (every 15 minute checks for 3 hours) - then order for soft belt. Complete medical work up...therapy to attempt strengthening exercise..."</p> <p>Medical record review of the Falls Prevention Program Interventions dated July 3, 2012, revealed, "...q 15 min (checks) x 3 hrs. Soft belt when up in w/c - complete medical work up."</p> <p>Medical record review of the Care Plan revealed it was updated July 3, 2012, "...Med (medical) workup. Q 15 min x 3 hrs" and the soft belt when up in the wheelchair was not included on the care plan.</p> <p>Review of the fall investigation 72 Hour Follow-up dated July 6, 2012 (for the fall July 3, 2012), revealed, "...No injury. (Increased) confusion noted. Q 15 min (checks) x 3 (hours). Soft belt when (up) in w/c. Requested complete medical work (up)..."</p> <p>Medical record review revealed the medical</p>	N 424	<p>#95</p> <p>Treatment plan and falls interventions were reviewed by DON, ADON, and MDS Coordinator on 6/20/13 with clarification of lotion with pump spout being removed (slick floor) and encouraged family regarding not bringing that type of lotion and staff will assess resident items with care on 6/24/13. Fall interventions for this resident are nonskid socks, keep environment clean of lotions or anything on floor. DON assessed the resident and reviewed care plan on 6/25/13, resident in w/c, no distress noted. Direct care staff was in-serviced on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plans by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/20/13 ensuring proper devices were in place and operational (bed and chair alarms).</p>		

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N 424	<p>Continued From page 6</p> <p>workup was not completed until July 5, 2012, with orders for labwork. Continued medical record review revealed the resident had a urinalysis collected on July 6, 2012, with results of a UTI on July 9, 2012, and antibiotics were started July 9, 2012.</p> <p>Medical record review of a "Hey Therapy" (form used to request therapy screening) form dated July 9, 2012, revealed "frequent falls 7/1, 7/2, & 7/3..."</p> <p>Interview with the Rehabilitation Manager on June 12, 2013, at 11:00 a.m., in the 100 hall, revealed therapy had not evaluated or treated the resident related to the referral on July 9, 2012, and no new screen had been completed after the medical work up on July 5, 2012, had been completed.</p> <p>Medical record review of a Nurse's Note dated July 30, 2012, at 5:20 p.m., revealed, "...According to CNA...while passing out trays for dinner...heard a chair alarm sounding...was right by the room when the alarm started sounding...opened the door to investigate from the doorway...observed (resident #134) standing hunched over @ (at) the foot of (resident's) bed the chair alarm on (resident's) recliner was sounding...rushed to assist resident but before (CNA) could reach (resident) fell onto the bed and slid down to the ground..."</p> <p>Review of a facility fall investigation dated July 30, 2012, at 5:20 p.m., revealed "...slide down into floor...assessed for injuries - none noted...Pt between recliner and bed...resident's mental status before incident disoriented..."</p> <p>Medical record review of the Falls Prevention Program Interventions dated July 30, 2012,</p>	N 424	<p>#111</p> <p>Clinical Manager and DON/ADON reviewed care plans with changes noted being chair pad alarm Dc'd 6/19/13, alarming seat belt 6/19/13 after assessment by Clinical Manager. Fall interventions for this resident are fall mat on floor, nonskid shoes/slippers when out of bed, activity bundle at nurse's station when needed, bed alarm, and seat belt alarm. DON assessed resident and reviewed care plan on 6/24/13, resident up and in w/c in sunshine room. Direct care staff was in-serviced on 6/19/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random review, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/20/13 ensuring proper devices were in place and operational (floor mat, bed and seat belt alarms).</p>	

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N 424	<p>Continued From page 7</p> <p>revealed, "Res to be (up) in w/c for all meals in DR (dining room). Dep D/C (Depakote [medication used for seizures or psychiatric disorders] discontinued) 7/27/12" and no other new interventions to prevent falls.</p> <p>Medical record review of the fall investigation 72 Hour Follow-Up dated August 3, 2011 (for the fall July 30, 2012), revealed "...No injury. Resident to be encouraged to be (up) for meals..."</p> <p>Medical record review of a Nurse's Note dated August 2, 2012, at 11:00 a.m., revealed, "...At aprox 7:50 AM...went to resident's room immediately upon entering Resident was observed sitting on bottom in front of recliner c w/c on it's back in front of resident. Resident stated...was going home..."</p> <p>Review of a facility fall investigation dated August 2, 2012, revealed, "...0 injuries noted at this time...chair alarm was sounding...slid down front of chair...resident on floor in front of recliner. W/C in front of resident on its back...resident's mental status before incident disoriented..."</p> <p>Medical record review of the Care Plan updated August 2, 2011, revealed, "Res gotten (up) in w/c for day..."</p> <p>Medical record review of the fall investigation 72 Hour Follow-Up dated August 5, 2012 (for the fall on August 2, 2012), revealed, "...No Injury noted. Resident assessed & assisted to w/c vs (versus) recliner..."</p> <p>Interview with the Director of Nursing (DON) on June 12, 2013, at 10:09 a.m., in the conference room, confirmed the resident had been placed in the wheelchair for the day after the fall on August</p>	N 424	<p>#52</p> <p>This resident's interventions were assessed on 6/24/13 by Clinical Manager and DON with no clarifications required. DON assessed resident and care plan on 6/24/13 and checked bed wheels which were locked. Fall interventions for this resident are bed in low position, wheels locked, nonskid footwear, and house shoes within reach. Direct care staff was in-serviced on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/20/13 ensuring proper devices were in place and operational (bed in low position with wheels locked).</p>		

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N 424	<p>Continued From page 8</p> <p>2, 2012. Continued interview confirmed no other intervention had been put in place to prevent the resident from falling from the recliner and the intervention for "up at meals" had not been followed.</p> <p>Medical record review of a Nurse's Note dated August 3, 2012, at 4:00 p.m., revealed, "...found pt (patient/resident #134) sitting outside...bedroom doorway. Upon arrival to area, Pt has knot c bruise to (L) eyebrow area...</p> <p>Review of a facility fall investigation dated August 3, 2012, revealed "...found pt on floor sitting outside (resident's) bedroom doorway...alarm not sounding...connected properly...no...resident's mental status before incident disoriented..."</p> <p>Medical record review of the Care Plan updated August 3, 2012, revealed "Redirection of CNA (Certified Nurse Assistant) - q 15 min (checks)."</p> <p>Review of the fall investigation 72 Hour Follow-Up Report dated August 6, 2012, revealed, "...CNA redirected r/t (related to) alarm..."</p> <p>Interview with the Director of Nursing (DON) on June 12, 2013, at 10:09 a.m., in the conference room, confirmed the staff failed to ensure the resident's alarm was in place prior to the fall on August 3, 2012, and no new intervention was implemented after the fall on August 3, 2012. Continued interview confirmed the staff were to check safety alarms with each resident contact. The DON stated this had not been done due to "human error."</p> <p>Medical record review of a Nurse's Note dated August 12, 2012, at 5:20 p.m., revealed, "...I was called into pt room pt was found laying on back in</p>	N 424	<p>#193 Resident chart reviewed on 6/24/13 by Clinical Manager and DON. Resident was sent back to hospital on 6/12/13 at 7:05pm due to slurred speech. On 6/14/13, resident sent back to facility from Memorial Hospital after another "episode, resident arrived at facility at 7:45pm - MD order to send to Erlanger - non-verbal vs stable. Report from Memorial Hospital - no acute abnormality of MRI brain. Resident sent via EMS at 7:55pm. Resident discharged to hospital.</p> <p>#2 Clinical Manager, DON/ADON reviewed care plan on 6/24/13. No changes or clarifications were made at the time. Fall interventions for this resident are nonskid socks. Direct care staff in-serviced again on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. Direct care staff in-serviced regarding chair to sit in when making phone calls, encouraging rest periods, husband education on asking for assistance, bed alarm and chair alarm. ADON did a room check on equipment and</p>		

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N 424	<p>Continued From page 9</p> <p>floor w/ (with) head @ bathroom door feet toward recliner where res was sitting prior to fall...no hip pain noted...Lg (large) ST (skin tear) to (R) elbow...ROM (range of motion) WNL (within normal limits) to legs...Pt denies any pain pt instructed to not get up unast (unassisted) and to press call light for ast (assistance) pt up in...w-chair (wheelchair) @nurse's station with soft belt in place @ present..."</p> <p>Medical record review of a nurse's note dated August 12, 2012, at 10:45 p.m., revealed, "...Resident has been c/o (increased) back and (R) hip pain. Had difficulty c transferring from w/c to Recliner & toilet this shift. Call made to (physician) and he stated 'give one hydrocodone (narcotic pain medication) 7.5/325 mg (milligrams) now and continue c scheduled PRN dosage' also stated that 'I will make a decision on (resident) tomorrow.' Pain pill given...Mobility to (R) leg is limited, pt c/o pain when trying to move leg..."</p> <p>Medical record review of Nurse's Notes dated August 13, 2012, at 3:30 a.m., revealed, "...Res cont (continue) to c/o pain to (R) hip...10:00 a.m. - resident c/o pain when being moved, called (physician) received new order x-ray right hip and leg...11:00 AM...mobile here to xray resident- Resident very uncomfortable being turned and repositioned...1:00 PM...There is a complete acute - to subacute fracture involving right femoral neck at the subcapital region with largest distal fragment displaced superolaterally 1 cm (centimeter) appearing new in the interval. Called (physician)...4:00 PM - received new order per (physician) - Send to ER immediately..."</p> <p>Review of a facility fall investigation dated August 12, 2012, revealed "...click seat belt was not</p>	N 424	<p>environment on 6/19/13 ensuring proper devices were in place and operational (bed alarms and chair alarms).</p> <p>#18 Resident care plan reviewed on 6/24/13 by Clinical Manager, DON/ADON with clarifications made for rehab referral on 6/16/13. 6/20/13 ambient music at specific times, offer toileting while awake. Fall interventions for this resident are bed against wall, bed alarm, chair pad alarm in w/c, nonskid socks, ambient music, anti-roll back brakes on w/c. Direct care staff in-serviced again on 6/24/13 by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment and environment on 6/19/13 ensuring proper devices were in place and operational (bed alarms, chair pad alarms, anti-roll back brakes on w/c).</p>		

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N 424	<p>Continued From page 10</p> <p>sounding. CNA...states 'I put it on'...resident's mental status before incident disoriented..."</p> <p>Medical record review of the Care Plan updated August 12, 2012, revealed "...low bed - removed recliner from room."</p> <p>Medical record review of a Consultation from the hospital admission dated August 13, 2012, revealed "...patient...fell last night...put in bed...this morning they tried to get (resident) up had excruciating pain in...hip, unable to walk...history of frequent falls...X-Ray: subcapital fracture, right femur...Assessment and Plan: 1. Fall with hip fracture...Will go ahead and clear (resident) for surgery..."</p> <p>Medical record review revealed the resident was re-admitted to the facility August 17, 2012, following surgery for an Endoprosthesis Right Hip for Neck Fracture.</p> <p>Interview with the Director of Nursing (DON) on June 12, 2013, at 10:09 a.m., in the conference room, confirmed resident #134 had a total of seven falls prior to the fractured right hip; the facility had knowledge the resident removed the alarming seat belt; the resident had been disoriented at the time of each fall and the facility instructed the resident to use the call light as an intervention for two of the falls. Continued interview revealed the interventions put in place for "up at meals" and "chair alarm" had not been followed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on June 17, 2013, at 10:19 a.m., by telephone, revealed the nurse had been aware the resident had confusion, history the resident removed the alarming seat belt, and had a history of falls from</p>	N 424	<p>#13</p> <p>Resident review of restraint on 6/19/13 by DON, Clinical Manager, and Rehab Director. Insured restraint on per manufacturer's instructions. Posey Company conducted an in-service on Monday, 6/24/13 regarding restraint placement and Rehab Director continues to in-service CNAs, LPNs, RNs and Rehab staff on proper placement of restraint. Medical Director and Administrator approved revised fall prevention policies (A) and procedures including Falls Incident Packet (B), Alarm Policy (C), Tracking log (E) and checks (D) on 6/25/13. On 6/25/13, DON met with Clinical Managers, ADON, Staff Development Nurse, and MDS nurses to review and revise above policies and forms (A,B,C,D,E) and develop process for implementation and monitoring of these. Mandatory in-servicing on developed forms B,C,D and E to CNAs, LPNs, and RNs on 6/25/13 by DON and/or Clinical Managers and Staff Development Nurse. No CNA, LPN, or RN will be allowed to work until in-serviced on policies and procedures B, C, D, and E. In-services on policies B,C, D, and E will be conducted on an ongoing basis with follow-up tests (F) and then follow-up tests (F) every 3 months. In-services will be conducted by DON, ADON, Clinical Managers and/or Staff Development Nurse.</p>		

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N 424	<p>Continued From page 11</p> <p>the recliner. Continued interview revealed, "we just tried to watch (the resident) as much as we could."</p> <p>Review of a fall investigation dated September 14, 2012, revealed resident #134 fell at 3:40 p.m., "...resident was observed on floor near bed...bed alarm was in place...Bed alarm was not working when touched...Bed alarm malfunctioning when alarm box button pushed - Alarm was working wires were tangled around bed rail. After untangling Bed alarm worked then stopped. New bed alarm placed..."</p> <p>Review of manufacturer's recommendations for the alarm revealed "the alarm and sensor pad should be checked prior to each use for proper functioning...install batteries...affix Alarm holder securely to side of bed out of sight and reach of the resident...secure excess cord to avoid damage...Caution!...this product is designed to be a monitor, alerting staff when a patient has risen from their bed or chair...to be used in conjunction with a total fall prevention program...Do Not assume!...This product must be tested each time it is used with a patient to make sure it functions properly...12 Month Limited Warranty Personal Safety Corporation warrants this product to be free from factory defects in materials and workmanship for a period of 12 months from the date of the product..."</p> <p>Observation and interview with Certified Nurse Assistant #2 on June 17, 2013, at 1:23 p.m., in the resident's room, revealed an alarming bed pad on the resident's bed in use for the resident. Continued interview confirmed the manufacturer's date on the bed alarm pad was June 2011 and no other date was visible on the pad.</p>	N 424	<p>2. On 6/20/13, DON/ADON, Clinical Managers and Staff Development Nurse assessed all residents with falls to ensure appropriate interventions are in place. Residents at risk: 25 residents were identified at risk on 6/25/13 having falls with the past 45 days. Three resident interventions were updated on nursing careplans after Clinical Manager/DON/ADON/Staff Development Nurse reviewed. Updates charted by Clinical Manager and/or ADON/Staff Development Nurse. Direct care staff in-serviced by Clinical Manager and then in-service information placed in the in-service communication book and interventions added to nursing and CNA Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or longer as appropriate to monitor staff awareness. This will be reviewed by DON/ADON, Staff Development Nurse for compliance - random reviews, two times a week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. The other 22 resident interventions already in place are still current and effective. All devices were tested for functionality per ADON, completed 6/23/13 and ongoing per policy (D), chair and bed alarm policy were put into place (C), assessment of assistive device (E), and alarm check forms (D). New interventions will be determined per resident need and nurses have been given a falls prevention - potential interventions (M) for assistance to nurses when determining care for residents when need is evident by occurrence.</p>		

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N 424	<p>Continued From page 12</p> <p>Interview with the DON on June 17, 2013, at 5:00 p.m., in the DON office, revealed the facility did not designate one person to monitor the alarm pads for proper functioning/usage and was not aware the staff did not put batteries in the bed alarms. Continued interview revealed the facility had not developed a policy and procedure for the alarming pads. Continued interview confirmed the facility had knowledge resident #134 had a history of falls from the recliner in the resident's room; removed alarming seat belt per self; had a history of confusion and not following commands; was unable to use a call light to request assistance; and had knowledge staff had not applied the chair alarm to the resident on August 3, 2012. Continued interview confirmed the facility continued to place the resident back in the recliner in the resident's room after the resident had fallen four times and failed to provide adequate supervision to prevent accidents and on the fifth fall the resident fractured the right hip.</p> <p>Resident #37 was admitted to the facility on August 12, 2011, with diagnoses including Cardiomegaly, Atrial Fibrillation, Diabetes, Osteoarthritis, Senile Dementia, Abnormality of Gait, Macular Degeneration, Chronic Renal Failure, and Senile Depression.</p> <p>Medical record review of the Quarterly Assessment dated November 15, 2011, revealed the resident scored a 10 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. Further review revealed the resident required limited assistance of one person for transfers, ambulation, and toileting, and was occasionally incontinent of bowel and bladder.</p> <p>Review of the resident's Activities of Daily Living</p>	N 424	<p>On 6/25/13, DON/Clinical Managers placed the falls incident packet (B) on each Nursing station for use after staff in-servicing began on 6/25/13.</p> <p>3. Beginning 7/15/13 the charge nurse on each nursing unit will implement new interventions to be determined per resident need as evident by an occurrence. On 7/12/13 the Staff Development Nurse placed a falls prevention – potential interventions (M) for assistance to nurses when determining care for residents when a fall occurrence happens. Nurses will update nursing careplans and CNA careplans if occurrence occurs. On 7/15/13, the DON reviewed all incidents which includes falls within 72 hours for appropriate interventions, care planned with new interventions and investigated accurately</p> <p>4. Clinical Manager/Weekend Supervisor to review in-service sheets and signatures daily until July 15, 2013, then weekly. DON and/or ADON, Staff Development Nurse will review in-service sheets two times a week until August 26, 2013 and then weekly for compliance. CNA careplans and nursing careplans regarding fall occurrences will be reviewed by Clinical Manager and MDS Coordinator with each occurrence. The outcomes of the monitoring tools put in place (Falls Incident Packet (B), falls intervention roster, alarm checks (D) will be reviewed by DON and/or ADON, Staff Development Nurse every two weeks beginning 7/15/13. Beginning at the July QAPI meeting, outcomes of the falls, careplan, alarms and intervention roster monitoring tools were submitted to QAPI committee by the DON and the Administrator will report outcomes to the governing body at his meetings.</p>		

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N 424	<p>Continued From page 13</p> <p>(ADL) Care Plan dated August 24, 2011, and last updated on March 19, 2013, revealed "...use a gait belt for all transfers...insure that...footwear is non-slip...assist...in transfer with extensive performance with assist of 2 staff assist..."</p> <p>Review of a facility fall investigation dated February 3, 2012, at 8:00 p.m., revealed the resident had a bruise to the left ring finger and reported the bruise to the staff. Continued review of the investigation revealed "...the bruise was caused by a fall...this morning...no fall was reported...told nurse...hit hand on the side rail...no evidence of fall..."</p> <p>Medical record review of a Nurse's Note dated February 13, 2012, at 12:30 p.m., revealed, "Res (resident) found in floor on knees in front of sink...Res has increased confusion...Res had removed chair alarm box et (and) removed batteries. Placed box where res couldn't reach it...1:45p (p.m.) res up amb (ambulating) around room. Res turned off alarm on chair. CNA assisted res to sit down...2pm Res up walking. When CNA tried to redirect res, res became agitated..."</p> <p>Review of a facility fall investigation revealed "...the resident was attempting to use garbage can as toilet et fell on...knees in front of can...res removed alarm from chair et removed battery...c/o pain to L (left) ring finger...Safety Device in place prior to fall Chair alarm pad..." Further review revealed "...xray done 2-14-12 results: 4th middle finger phalanx (bone) with slight displacement...buddy tape finger (taping the broken finger to the finger next to it)..."</p> <p>Medical record review of the resident's Falls Risk Assessment dated February 13, 2012, revealed</p>	N 424			

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N 424	<p>Continued From page 14</p> <p>"...total score 24...total score of 10 or above represents high risk..."</p> <p>Medical record review of the Falls Prevention Program Interventions dated February 13, 2012, revealed "...reposition chair alarm...q1h (every one hour) toileting, PT/OT/SS (Physical Therapy/Occupational Therapy/Social Services) eval...1:1 (one to one means one staff person to one resident for direct supervision) c (with) resident d/t (due to)...depressed state..."</p> <p>Medical record review of an OT evaluation dated February 14, 2012, revealed "...continue with restorative services...recommend supervision for fall prevention..."</p> <p>Review of the facility's fall investigation 72 Hour Follow-Up (for the fall on February 13, 2013) dated February 16, 2012, revealed the facility interventions were chair alarm (which was in place prior to the fall), every one hour toileting, one-to-one (1:1) supervision, and Physical Therapy (PT) evaluation, Occupational Therapy (OT) evaluation.</p> <p>Medical record review of a Nurse's Note dated February 24, 2012, revealed, "3:50 AM - resident (#37) attempted to transfer self to BR (bathroom), before staff could get to res room, resident fell in room. Resident c/o (R) (right) hip pain..."</p> <p>Review of a facility investigation dated February 24, 2012, at 3:50 a.m., revealed "...resident attempted to ambulate to BR (bathroom) s (without) assistance resulting in a fall...c/o hip pain...sent to ER (emergency room)...hip fx (fracture) r (right)...." Further review of the investigation revealed at the time of the fall the resident had an alarm in place and sounding and</p>	N 424			

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N 424	<p>Continued From page 15</p> <p>was wearing pajamas and socks (not wearing non-skid socks). Interventions to prevent another fall were to "...make sure resident is wearing non-skid (skid) socks (an intervention which was to be in place from the February 13, 2012 fall)...encourage resident to use call light..." The resident was sent out to the Emergency Room and admitted to the hospital.</p> <p>Review of a hospital radiological interpretation dated February 24, 2012, revealed "...evidence of a right acetabular (hip) fracture..."</p> <p>Review of the Falls Prevention Program Interventions dated February 24, 2012, revealed the resident fell at 3:50 a.m., "...Resident climbed OOB (out of bed) et attempted to ambulate to RR (restroom)...transfer to ER + (positive for) hip fx - Returned to facility NWB (non-weight bearing - no weight to be placed on the leg), PT/OT. NO (new order) for soft belt due to unsteady gait et cognitive impairment."</p> <p>Medical record review revealed resident #37 was readmitted to the facility from the hospital on February 28, 2013, following non-surgical treatment for the hip fracture.</p> <p>Medical record review of the falls risk assessment dated February 28, 2012, revealed the resident scored a 22.</p> <p>Interview with the Director of Nursing (DON) on June 18, 2013, at 5:40 p.m., in the DON's office, confirmed the facility failed to ensure interventions of non-skid socks and 1:1 supervision was done as required following the fall on February 12, 2013.</p> <p>Medical record review of the Care Plan dated</p>	N 424			

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N 424	<p>Continued From page 16</p> <p>March 8, 2012, with goal and intervention dates updated June 8, 2012, September 6, 2012, November 16, 2012, February 13, 2013, and May 5, 2013, revealed, "Fracture...right displaced Acetabulum (socket of the hip joint) & (and) Fractured Ramus (pubic bone) of the right side inferior r/t (related to) fall on 2/24/12...provide 1:1 (one on one) interventions to prevent further falls or injuries...Occupational Therapy...Physical Therapy...requires assist of two staff for transfers...only to bear weight on...left leg only..."</p> <p>Medical record review of the Quarterly Assessment dated May 20, 2012, revealed the resident scored a 3 on the BIMS, indicating severe cognitive impairment. Further review revealed the resident required extensive assistance of two persons for transfers and toileting, and was totally dependent on staff for locomotion. Continued review revealed the resident was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>Medical record review of the falls risk assessment dated May 27, 2012, revealed the resident scored a 22.</p> <p>Medical record review of a Hospitalization and ER Visit Record revealed the resident fell and was sent to the ER on June 16, 2012.</p> <p>Review of a facility investigation dated June 16, 2012, at 6:30 p.m., revealed "...resident got off toilet by...self and fell to floor...hitting head...swelling 1/2 (one-half) dollar size felt L (left) occipital (lower back side of head) area...CNA (certified nursing assistant) had left (resident) in the bath room by...self...sent to ER returned 6-17-12..."</p>	N 424			

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N 424	<p>Continued From page 17</p> <p>Medical record review of the Emergency Room documentation dated June 16, 2012, revealed "...presented via EMS (emergency medical service) after fall at the NH (nursing home)...fell with in the bathroom, straight back and hit back of...head, unknown LOC (loss of consciousness)...recent ORIF (open reduction internal fixation) of...right hip, is supposed to be NWB (non-weight bearing) to RLE (right lower extremity)...Clinical Impression...Closed Head Injury: Minor Concussion without Loss of Consciousness...Contusion, Head, Contusion Right Hand, Contusion, Proximal Right Lower Extremity..."</p> <p>Medical record review of the ER radiological interpretation of a CT (Computed Tomography) of the Head dated June 16, 2012, revealed "...small left posterior parietal scalp hematoma (swelling to an area of the head from blood accumulation due to a broken blood vessel)..."</p> <p>Medical record review of the resident's Falls Risk Assessment dated June 16, 2012, revealed "...total score 21..."</p> <p>Review of the Falls Prevention Program Interventions dated June 16, 2012, revealed, "...Resident was left unattended on toilet by CNA...ER eval...Staff inservicing...CNA re-directions...PT/OT referral..."</p> <p>Review of the facility's fall investigation 72 Hour Follow-Up dated June 19, 2012, revealed, "...Sent to ER returned 6-17-12 @ (at) 1135 PM c Dx (with diagnosis of) Concussion/Contusion...CNA left Resident unattended on toilet. CNA redirected. Staff inserviced..."</p> <p>Interview with the Director of Nursing (DON) on</p>	N 424			

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N 424	<p>Continued From page 18</p> <p>June 18, 2013, at 5:40 p.m., in the DON's office, confirmed the facility did not follow falls interventions of no weight on the left leg and 1:1 interventions, and the resident was left alone on the toilet, resulting in the fall.</p> <p>Medical record review of an OT note dated June 29, 2012, revealed "...requires one person A (assist) for self-care secondary to decreased safety awareness from dementia..."</p> <p>Medical record review of the Quarterly MDS dated August 14, 2012, revealed the resident #37 scored a 3 on the BIMS, indicating severe cognitive impairment. Further review revealed the resident required extensive assistance of two persons for transfers and toileting, and was totally dependent on staff for locomotion. Continued review revealed the resident was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>Medical record review of the Hospitalization and ER Visit Record revealed the resident had a fall on September 30, 2012, with no injury.</p> <p>Review of a facility fall investigation dated September 30, 2012, at 5:35 a.m., revealed, "...staff alerted to room by bed alarm. Resident was lying on the floor with...feet toward...bed...head near vanity...wc (wheelchair) was turned over...contusion L (left) side of forehead..."</p> <p>Review of the Falls Prevention Program Interventions dated September 30, 2012, revealed, "...Fall attempting to get OOB by pulling on w/c. Obtained contusion to head...Intervention is to put w/c away p (after) res going to bed & (check) Res early in AM to see if...wants to get</p>	N 424			

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N 424	<p>Continued From page 19</p> <p>(up)..."</p> <p>Review of the fall investigation 72 Hour Follow-Up dated October 3, 2012, revealed, "X-ray (negative) for fx. Bruising to (L) side of face. CNAs instructed to put w/c away p resident goes to bed and (check) early in AM (morning) to see if...wants to get OOB (out of bed)..."</p> <p>Review of the Quarterly Assessment dated January 29, 2013, revealed the resident scored a 3 on the BIMS, indicating severe cognitive impairment. Further review revealed the resident required extensive assistance of two persons for transfers and toileting, and was totally dependent on staff for locomotion. Continued review revealed the resident was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>Medical record review of the Care Plan dated February 5, 2013, "Falls...Falls, at risk for, potentially related to...use of assistive device, physical restraint use, must be assisted at all times with transfers and ambulation with limited assistance of 1-2 staff, history of fracture, impaired cognition, unsteady transfer...unsteady gait...Uses pressure sensor alarm when...in bed...CNAs to use gait belt with all transfers and with ambulation, with proper technique and to always have assistance when transferring this resident...falling friends program...visual checks q1hr (every one hour) when out of bed..." Further review of the Care Plan revealed the Care Plan had continued to be updated for the Category Problem of Fracture, dated February 13, 2013, with the previously listed interventions of "...Provide 1:1 interventions to prevent further falls or injuries..."</p> <p>Medical record review of the Hospitalization and</p>	N 424		

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N 424	<p>Continued From page 20</p> <p>ER Visit Record revealed the resident had a fall on March 19, 2013, without injury.</p> <p>Review of a fall investigation dated March 19, 2013, at 4:50 p.m., revealed "...found res (resident) in w/c lying in floor on r (right) side. W/C turned over with resident inside w/c. Soft belt intact...in front of closet...bruise to r elbow...c/o bil (bilateral) hip et leg pain...ER treatment (box checked yes)..."</p> <p>Review of the Falls Prevention Program Interventions dated March 19, 2013, revealed, "...Res had fall - intervention q 1 (every one hour) visual checks x 72 (hours)..."</p> <p>Medical record review of the Care Plan for Falls dated February 5, 2013, revealed "3/19/13" was written in ink before the typed print of "Visual checks Q 1 hr when out of bed" and "x 72" was written after the typed sentence.</p> <p>Review of the fall investigation 72 Hour Follow-Up dated March 22, 2013, revealed, "...staff to encourage resident to ask for assistance when wants something from the closet..."</p> <p>Observation and interview with resident #37 on June 17, 2013, at 3:25 p.m., in the resident's room, revealed the resident sitting beside the bed in a wheelchair with a soft belt secured around the resident's abdomen. The resident's bed was against the wall on the left side and a fall mat was on floor on the right side of bed. The resident was asked about the call light attached to the bedspread and the resident responded "I don't know what that is." Proceeded to ask the resident about a piece of clothing lying on the bed and the resident could not confirm if it belonged to the resident. The resident was asked if had</p>	N 424		

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N 424	<p>Continued From page 21</p> <p>fallen and the resident responded by saying "I don't think so."</p> <p>Interview with CNA #5 on June 18, 2013, at 4:55 p.m., in the Wing 4 dining room, revealed, "...1:1 (which had been part of the care plans and facility's documented interventions since February 13, 2012) can mean different things...it just depends on what's going on...some residents go behind nurses' station, others to their rooms, some to the Sunshine room, and some are brought into the dining room and we watch them in here...we can have several in here...the secretary watches residents that sit behind the nurses' station..."</p> <p>Interview with CNA #6 on June 18, 2013, at 5:02 p.m., in the Wing 4 dining room, revealed, "...1:1 (direct supervision of one resident by a staff person) are watched most of the time at the nurse's station..."</p> <p>Observation and interview with Unit Secretary #1 on June 18, 2013, at 5:03 p.m., at the Wing 4 nurses' station, revealed one resident sitting behind the nurse's station in a wheelchair. The Unit Secretary revealed "(a resident) falls so they bring (the resident) so I can watch...I have had 3 or 4 at a time to watch, sometimes another CNA is back here to help me, it is according to what is going on...watched two residents last night from 3:30 p.m. until 9:55 p.m..."</p> <p>Interview with the Assistant Director of Nursing (ADON) on June 18, 2013, at 5:15 p.m., in the conference room, revealed "1:1 means someone stays and talks with (the resident) until (she/he) is calm, it may be a nurse or a CNA. The nurse determines when 1:1 starts and ends."</p>	N 424		

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N 424	<p>Continued From page 22</p> <p>Interview with the Director of Nursing (DON) on June 18, 2013, at 5:40 p.m., in the DON's office, confirmed the facility did not follow the falls interventions for the resident including 1:1 supervision or every one hour visual checks.</p> <p>Resident #58 was admitted to the facility on March 14, 2013, with diagnoses including Alzheimer's Disease, Diabetes Mellitus, and Difficulty in Walking.</p> <p>Medical record review of an Admission Minimum Data Set (MDS) dated March 18, 2013, revealed the resident had severe cognitive impairment and required extensive assistance of two for ambulation.</p> <p>Review of the Nurse's Notes dated April 13, 2013, revealed, "4 pm Resident up in w/c at nurses station waiting on (EMS - Emergency Medical Services) to arrive to transport to...ER. Writer was called to wing 1 dining room. Patient was lying supine in floor in front of w/c. Patient from Wing 2 was in Wing 1 dining room told...Unit Sec (Secretary) 'Pt needs assistance' Page overhead by Unit Sec...Resident was observed in front of (resident's) w/c in floor lying supine. Large ST x 2 (two skin tears) to (L) FA (left forearm) and x1 ST to medial (L) arm...w/c alarm was sounding...6:30 pm received report from...ER. Resident being sent back...CT normal..."</p> <p>Medical record review of the Care Plan updated April 13, 2013, revealed, "...Falls...4/13/13...brought res (resident) out of DR (dining room) to desk area, q (every) 1-2 hours checks, weighted blanket..."</p> <p>Review of a Care Plan (no date) placed in the resident's closet revealed "...Certified Nursing</p>	N 424			

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N 424	<p>Continued From page 23</p> <p>Assistant Goals: to sunshine room when wife is not present...weighted blanket..."</p> <p>Medical record review of a Sunshine Room Referral dated April 16, 2013, revealed "Please eval approp for SS (evaluate appropriateness for Sunshine) - d/t needing closer attn. (attention) & possible (increased) level of activity in order to circumvent agitation...Social Services: Wife's presence will be an issue. Only when she is not present...Activities: Appropriate for smaller setting...Selection Outcome: Fall risk - no restraint. Hours - when wife not here during SS (Sunshine) room hours..." Review of the evaluation revealed the resident was to be in the Sunshine Room during Sunshine Room hours if the wife was not visiting in the facility.</p> <p>Review of the Sunshine Room Guidelines dated November 6, 2012, revealed, "...To provide a safe, monitored environment for a small group...Residents with, but not limited to restraints, behavior issues, increased safety issues will be assessed for participation...nursing department will provide the needed staffing. A ratio of not greater than 1:6 (one staff per six residents) will be maintained with at least one CNA (certified nursing assistant) as facilitator...The Sunshine Room is open 5-7 days a week and provides care for 10 hours daily. How long the participants stay and for which activities depends on individual needs and behaviors."</p> <p>Medical record review of a Nurse's Note dated May 13, 2013, at 6:50 p.m., revealed, " Resident was sitting in w/c at nurses station. Personal alarm sounded and nurse noted resident standing in front on w/c...stepped to right and tripped over foot rest. Fell backwards and hit head. Nurses</p>	N 424			

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N 424	<p>Continued From page 24</p> <p>unable to get to resident. C/O (L) hip pain...Received orders to send to ER..."</p> <p>Medical record review of a Nurse's Note dated May 14, 2013, at 1:30 a.m., revealed the resident returned to the facility from the ER.</p> <p>Medical record review of a Nurse's Note dated May 14, 2013, at 2:00 p.m., revealed, "Received CT results from...ER reports findings of small approx. 2 cm length acute minimally displaced fx (Rt) (Right) iliac crest (hip)..." and the resident was transported to the Orthopedic physician's office and returned to the facility the same day.</p> <p>Medical record review of a Positioning/Splinting/ADL Screen form (with a referral date of May 15, 2013) revealed, "...Reason for Referral Recent fall/Sunshine Room...Also recommend sunshine room (a previous referral/recommendation for Sunshine Room was already in place from April 13, 2013, fall) in afternoons when more alert for more one on one engagement in activities to (decrease) need for restraint & to promote fall prevention..."</p> <p>Review of a fall investigation 72 hour Follow-Up dated May 16, 2013 (for the fall May 13, 2013), revealed, "...Sent to E.R. fx (R) iliac crest...Rehab to screen. Medical work (up) done. Sunshine room referral (an intervention which was completed and put in place April 16, 2013)..."</p> <p>Medical record review of the Care Plan revealed it was updated May 13, 2013, "5/13/13...1:1 as needed...Sunshine Room (small focus group) when up in W/C (wheelchair)..." Further review revealed the Sunshine Room had not been placed on the Care Plan at the time of the referral on April 16, 2013.</p>	N 424			

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N 424	<p>Continued From page 25</p> <p>Observation on June 18, 2013, at 10:40 a.m., in the resident's room, revealed the resident lying on the bed, bed alarm in place, and wheelchair at bedside with chair alarm on back of chair.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on June 18, 2013, at 10:43 a.m., at the nurse's station, revealed when the resident is up in the wheelchair the staff placed a chair alarm, weighted blanket in the resident's lap, and "goes straight to the Sunshine Room."</p> <p>Observation on June 18, 2013 at 11:36 a.m., at the Nurse's Station, revealed the resident sitting in a wheelchair with the chair alarm and the weighted blanket in place.</p> <p>Interview with the Certified Nursing Assistant (CNA) #1 on June 18, 2013, at 1:18 p.m., in the 100 hallway, revealed the CNA had placed the resident in the wheelchair at the Nurse's Station, and the CAT (care assistant tech) was instructed to take the resident to the SS room. Continued interview revealed the resident was at the desk for twenty minutes before being transferred to the Sunshine Room.</p> <p>Interview with the Director of Nursing (DON) on June 18, 2013, at 2:10 p.m., in the DON office, revealed the resident was placed in the Sunshine Room as an intervention to prevent further injury when up in the wheelchair. Further interview confirmed the facility failed to follow an intervention to prevent accidents for resident #58.</p> <p>Resident #71 was admitted to the facility on January 17, 2011, with diagnoses including Alzheimer's Disease, Anxiety, Dementia, and Osteoarthritis.</p>	N 424		

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N 424	<p>Continued From page 26</p> <p>Medical record review of the Care Plan dated January 3, 2012, revealed the resident was at risk for falls and had four falls between June 25, and September 5, 2012. Falls interventions included "...bed alarm is on and working when in bed... Staff member to be present in common area at all times from 8AM to 8PM..."</p> <p>Medical record review of a falls risk assessment dated March 30, 2012, through May 30, 2013, revealed the resident had been assessed as high risk for falls.</p> <p>Medical record review of the Falls and ER Visit Record revealed the resident had a fall on September 9, 2012.</p> <p>Review of a fall investigation dated September 9, 2012, revealed "...was found on the floor (of another resident's room)...bed alarm not sounding...loose in the socket..."</p> <p>Medical record review of the Care Plan revealed it was updated September 9, 2012, "...Inserviced staff to monitor floors for spills...Inserviced staff -bed alarms to be checked at begin/end Q shift & c each episode of in bed care..."</p> <p>Interview with the DON on June 17, 2013, at 4:30 p.m., revealed no new intervention had been added after the fall September 9, 2012; the alarm had not sounded when the resident was found after the fall on September 9, 2012; and the resident was not supposed to be independent with ambulation. Continued interview revealed the facility had been unable to determine why the alarm had not sounded.</p> <p>Medical record review of the Care Plan revealed</p>	N 424			

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N 424	<p>Continued From page 27</p> <p>the Care Plan was updated after a fall on October 26, 2012, with "...Assistance of 1 staff for transfers, and ambulation, chair alarm..." Review of the Care Plan revealed the resident had another fall October 28, 2012.</p> <p>Review of a fall investigation dated October 28, 2012, revealed, "...When I came in the dining room resident was sitting up-right on the floor next to (resident's) walker..."</p> <p>Medical record review revealed the Care Plan was updated October 28, 2012, "...Cont. (continue) assist of one staff for transfers and ambulation, cont. alarm in chair..." Review of the Care Plan revealed the resident had a fall on December 4, 2012.</p> <p>Review of a fall investigation dated December 4, 2012, revealed, "...resident placed in geri chair b/c (because)...attempted to get out of the bed multiple times. Bed alarm sounded to alert staff of resident trying to get out of bed...walked up to nurses station and yelled '(resident) is in floor'...No alarm sounded as there was no alarm in chair..."</p> <p>Review of the fall investigation 72 Hour Follow-Up dated December 7, 2012, revealed, "...Staff to do q 15 min visual (checks) when (up) in Gerichair..."</p> <p>Medical record review of the Care Plan revealed an update December 4, 2012, "Q 15 min visual checks..."</p> <p>Medical record review of a quarterly assessment dated February 26, 2013, revealed resident #71 had severe cognitive impairment; required extensive assistance of two for transfers and ambulation; and balance during transitions and</p>	N 424			

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N 424	<p>Continued From page 28</p> <p>walking was not steady, only able to stabilize with staff assistance.</p> <p>Review of the Care Plan and the Falls and ER Visit revealed the resident had a fall on March 17, 2013.</p> <p>Review of a fall investigation dated March 17, 2013, revealed, "Writer was informed by Wing 2 receptionist that resident had fallen, was trying to stand and open restroom door on East Hall. Resident's actual fall was not seen by staff...w/c alarm sounding..."</p> <p>Review of the fall investigation 72 Hour Follow-Up dated March 20, 2013 revealed, "...Toileting schedule q 1 toileting offered when awake..."</p> <p>Review of the Care Plan revealed the care plan was not updated with any new interventions and the resident had a fall on March 23, 2013.</p> <p>Review of a fall investigation dated March 23, 2013, revealed "...w/c alarm sounding in Wing Two Dining Room...resident observed standing and walking...stumbled backwards and fell..."</p> <p>Medical record review of the Care Plan revealed a soft belt was applied on March 23, 2013.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on June 17, 2013, at 5:30 p.m., in the Administrator's Office, revealed the resident had an alarming chair pad in the stationary chairs in the Wing Three Common Area/Dining Room.</p> <p>Interview with the DON on June 17, 2013, at 5:00 p.m., in the Administrator's office confirmed the resident had fallen fifteen times in one year; the facility failed to follow interventions put in place of</p>	N 424			

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N 424	<p>Continued From page 29</p> <p>1) chair pad alarm in stationary chair, 2) staff in common area, and 3) monitoring of the resident to prevent independent ambulation, to prevent injury for resident #71, and failed to implement new interventions to prevent further falls for the falls on October 28, 2012, and March 17, 2013.</p> <p>Resident #95 was admitted to the facility on June 12, 2012, with diagnoses of Late Effect Cerebral Vascular Accident, Rehabilitation, Amputation Toe, Hypertension, Diabetes Mellitus, and Mitral Valve Disorder.</p> <p>Medical record review of a Quarterly Assessment dated December 4, 2012, revealed the resident was severely impaired cognitively, and required supervision of one for transfers.</p> <p>Medical record review of the Hospitalization and ER Visit Record revealed the resident had a fall with no injury on August 5, 2012.</p> <p>Review of a fall investigation dated August 5, 2012, revealed "...Upon entering (resident's room) noted Resident sitting on floor...Residents chair was directly behind (resident)...Fall from: Chair wheelchair...Resident has a personal alarm on the back of...wheelchair. At time of fall personal alarm was not connected properly thus did not sound when resident fell..."</p> <p>Review of the fall investigation 72 Hour Follow-Up dated August 8, 2012, revealed "... (changed) alarm on W/C to alarming chair pad..."</p> <p>Review of the Care Plan dated December 11, 2012, revealed, "...Falls...Risk for Falls...Assess environment for fall risk factors...Keep bed in low position and wheels locked...Ensure bed alarm is on and working when in bed...Ensure chair pad</p>	N 424			

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N 424	<p>Continued From page 30</p> <p>alarm is on and working when in wheelchair...Requires supervision and 1 person physical assist at times for transfers...Restorative for ambulation and ROM (range of motion)programs...Place on Falling Friends programs..."</p> <p>Medical record review of the Hospitalization and ER Visit Record revealed the resident fell January 6, 2013, with no injury.</p> <p>Review of a fall investigation dated January 6, 2013, revealed "...CNA...called this nurse to residents room where resident was seen sitting on floor c back to the window...Fall from bed...Bed Alarm? Sounding: No...bed alarm pad not working properly...new bed alarm placed..."</p> <p>Review of a fall investigation 72 Hour Follow-Up dated January 9, 2013, revealed, "...Bed alarm pad (changed)...Staff inserviced to have (resident) up & dressed around breakfast time..."</p> <p>Interview with the Director of Nursing on June 13, 2013, at 10:30 a.m., in the conference room, confirmed the facility failed to ensure the chair pad alarm had been connected on August 5, 2012, and failed to ensure the bed alarm pad was functioning on January 6, 2013.</p> <p>Resident #111 was admitted to the facility on August 24, 2010, with diagnoses including Atriovent Block First Degree, Cardiac Dysrhythmias, Cardiomegly, Congestive Heart Failure, and Sinoatrial Node Dysfunction.</p> <p>Medical record review of a Quarterly Assessment dated March 12, 2013, revealed the resident scored 1 of 15 on the BIMS, indicating severe cognitive impairment; required extensive</p>	N 424		

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N 424	<p>Continued From page 31</p> <p>assistance of at least two persons for transfers and ambulation; and was not steady for balance during transfers and walking.</p> <p>Review of a fall investigation May 21, 2013, at 6:30 p.m., revealed the resident had a fall from "...wheelchair in dining room wing 2...sitting on floor leaning on r (right) arm...alarm sounded...personal sitter had stepped away to push another resident who is wheelchair bound to hallway, already sitting upright in the floor in front of wheelchair..."</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on June 18, 2013, at 4:30 p.m., in the common area at the Wing 2 nursing station, confirmed the resident had been left alone in the dining area while the CNA assisted another resident out of the dining room. The CNA further stated did not know the resident was 1:1 (one on one) because all 1:1's "should be in the Sunshine room."</p> <p>Further review of the fall investigation revealed on June 4, 2013, at 4:30 a.m., "...heard pad/chair alarm sounding at nsg (nursing) st (station)...lying r (right) side...wc (wheelchair)...nurse was in med (medication) room...interventions 1:1, neuro checks...noted in NP (nurse practitioner) notebook...activity referral for early awakening prior to sunshine room attendance..."</p> <p>Medical record review of a nurse's note dated June 4, 2013, at 4:30 a.m., revealed "...heard pad/chair alarm sounding, this instant ran to pt (patient) @ (at) nurses desk, pt laying on rt (right) side...unwitnessed fall...noted on NP (Nurse Practitioner) book: started one on one care..."</p> <p>Medical record review of a nurse's note dated</p>	N 424			

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N 424	<p>Continued From page 32</p> <p>June 4, 2013, at 9:30 a.m., revealed "...discussed resident in morning committee: fall from w/c. Activity referral for early awakening prior to sunshine room attendance..."</p> <p>Medical record review of a nurse's note dated June 16, 2013 at 2:30 p.m., revealed "...res (resident) found in hallway between wing 1 et (and) wing 3 in floor in front of sofa by CNAs...note left in NP (Nurse Practitioner) book..."</p> <p>Review of a fall investigation dated June 16, 2013, at 2:30 p.m., revealed "...hallway between wing 1 and 3 in front of sofa from wc, (visitor) came around the corner and notified the CNA of resident in floor...staff inserviced on taking only 1 resident to restroom at a time..."</p> <p>Interview with CNA #3 on June 18, 2013, at 2:00 p.m., in the Wing 1 shower room, confirmed there was no staff member present at the time of the fall and the CNA was assisting another resident to their room, and was not providing 1:1 and the resident was not in the Sunshine room.</p> <p>Resident #52 was admitted to the facility on January 13, 2006, with diagnoses of Rehabilitation Process, Fracture of Clavicle, Difficulty in Walking, Muscle Weakness- General, Blepharitis, Hypertension, Hyperlipidemia, and Anemia.</p> <p>Medical record review of an assessment dated May 21, 2013, revealed the resident had a Brief Interview for Mental Status (BIMS) of 7, which indicated the resident had moderate difficulty with cognition. The MDS also indicated the resident needed the assistance of one person for transfers</p>	N 424		

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N 424	<p>Continued From page 33</p> <p>and locomotion on and off the unit.</p> <p>Medical record review of the resident's current care plan for falls initiated October 4, 2011, revealed the resident was at risk for falls.</p> <p>Medical record review of at the Falls Prevention Program Interventions dated June 3, 2013, revealed, "Fall getting back in bed p going to B.R. (bathroom). Bed rolled d/t not locked. Intervention inserviced staff on making sure beds are locked to (check) freq (frequently)..."</p> <p>Review of a fall investigation dated June 3, 2013, revealed the resident had a fall while trying to get out of bed at 3:35 a.m. The resident suffered a "... ½ dollar size hematoma to the right side of the forehead, and a ½ dollar size bruise to the right upper arm. The bed had moved when the resident tried to get up..."</p> <p>Interview with the Director of Nursing (DON), on June 12, 2013 at 2:05 p.m., in the conference room, confirmed the unlocked bed had been the cause of the resident's fall on June 3, 2013.</p> <p>Resident #193 was admitted to the facility on October 4, 2012, with diagnoses of Bacterial Pneumonia, Pulmonary Collapse, Hypothyroidism, Cardiomegaly, Delirium, Hypertension, and Leukocytosis.</p> <p>Medical record review of the quarterly assessment dated April 9, 2013, revealed the resident had a BIMS of 9, indicating moderate cognitive impairment. The MDS also revealed the resident required assistance of two for transfers, and assist of one for locomotion on and off the unit.</p>	N 424			

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N 424	<p>Continued From page 34</p> <p>Medical record review of the resident's current care plan for falls, initiated October 17, 2012, revealed the resident was at risk for falls.</p> <p>Review of a fall investigation dated October 30, 2012, revealed the resident had a fall from a wheel chair, picking something up from the floor, no injuries noted. Interventions to prevent further fall included "OT to look at positioning and replace the wheelchair cushion the family had supplied, and assistive device for reaching objects was implemented.</p> <p>Review of a facility restraint committee meeting for November 2012 indicated a chair pad alarm had been implemented.</p> <p>Observation of the resident on June 11, 2013, at 10:59 a.m., revealed resident #193 was on the floor, had fallen out of the wheelchair in the hallway outside of the resident's room, and was complaining of back pain. Continued observation revealed a laceration with bleeding to nose with swelling. The resident stated at the time of the fall the resident hit her head; was sitting in the wheelchair (pad alarm in place, not alarming), and leaned forward to pick up a glass which had dropped. The resident fell forward out of the wheelchair. Further observation revealed the resident was lifted back to the wheelchair by the Nurse Practitioner, Licensed Practical Nurse (LPN) # 1, Restorative Aid (RA) # 1, and CNA # 11. The resident was rolled to the nurses' station to await EMS (Emergency Medical Services).</p> <p>Interview with Physical Therapy Director (PTD) on June 12, 2013, at 9:10 a.m., in the conference room, revealed the wheelchair pad alarm was connected and worked when tested after the fall, before placing the resident back in the</p>	N 424		
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N 424	<p>Continued From page 35</p> <p>wheelchair, and did not know why the alarm did not work when the resident fell from the wheelchair on June 11, 2013.</p> <p>Interview with RA #1 on June 12, 2013, at 9:40 a.m., at the Wing 1 Nurses' station, confirmed no alarm was audible when approaching the resident after the fall on June 11, 2013.</p> <p>Interview with CNA # 11, on June 12, 2013 at 9:50 a.m., at the Wing 1 nurses station, confirmed no alarm was heard when approaching the resident after hearing the resident call out after the fall on June 11, 2013.</p> <p>Observation on June 11, 2013, revealed resident #193 was sent to the Hospital after the fall on June 11, 2013, with a fractured nose, per EMS, and returned to the facility around 7:00 p.m., on June 11, 2013, with steri-strips on the nose.</p> <p>Resident #2 was admitted to the facility on September 26, 2012, with diagnoses including Chronic Pain, Legal Blindness, History of Fall, Alzheimer's Dementia, Parkinson's, and Anemia.</p> <p>Observation with Unit Manager #1 on June 17, 2013, at 4:05 p.m., revealed the resident in bed resting with a bed pad alarm in place. Continued observation revealed the resident had an additional personal alarm to the bed and a personal alarm to the wheelchair.</p> <p>Medical record review of the current Care Plan dated October 8, 2012, revealed "...Falls, at risk for, potentially related to high medication use, use of assist device, impaired vision, personal history of falls, unsteady gait...Goal...Falls will be avoided and safety will be maintained...Intervention...October 8, 2012 Insure</p>	N 424			

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N 424	<p>Continued From page 36</p> <p>that...footwear is non-slip...October 9, 2012 Bed alarm...October 29, 2012 alarm in stationary chair, January 8, 2013 personal alarm..."</p> <p>Review of a fall investigation dated April 15, 2013, revealed "...resident in floor lying on left side with head toward foot of bed...stated...was trying to stand from sitting on bed and slid of bed into floor, noted resident had regular socks rather than nonskid socks...no injury..."</p> <p>Review of a fall investigation dated dated May 27, 2013, revealed "...Upon entering...room related to resident roommate request for assistance resident found lying on right side of bed. Feet at dresser with resident head at bottom of bed. Resident stated 'I was trying to get to the bathroom and fell'...Bed alarm sounding...no...black cord disconnected from alarm...no injury..."</p> <p>Interview and review of the medical record and facility investigation with the Director of Nursing (DON) in the conference room on June 18, 2013, at 9:13 a.m., confirmed the intervention of non skid socks, which were to be on the resident, were not in place at time of the April 15, 2013, fall and the bed alarm was not functioning at the time of the May 27, 2013 fall.</p> <p>Resident #18 was admitted to the facility on April 2, 2011, with diagnoses including Depressive Disorder, Anxiety, and Bipolar.</p> <p>Medical record review of the current Care Plan dated March 15, 2013, revealed "...fall risk...difficulty in walking...Intervention...Insure that footwear is non-slip..."</p> <p>Review of a fall investigation dated April 1, 2013,</p>	N 424			

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N 424	<p>Continued From page 37</p> <p>revealed "...CNA (certified nursing assistant) called to room...resident was sitting on buttocks with back toward bed and right leg out in front and left leg bent at knee...resident reported...was trying to get out of wheelchair...Environment...resident did not have on non-skid socks on prior to fall...no injury..."</p> <p>Interview and review of medical record and facility investigation with the DON on the 100 hall on June 18, 2013, at 9:02 a.m., confirmed the non skid socks, which were to be on the resident, were not on at the time of the fall.</p> <p>Resident #13 was admitted to the facility on September 12, 2008, with diagnoses including Personal History of Fall, Hip Fracture, Senile Dementia, Anxiety, and readmitted on December 27, 2012, with diagnoses Left Above the Knee Amputee.</p> <p>Medical record review of a Care Plan dated January 9, 2013, revealed, "...At risk for falls R/T (related to)...bilateral above the knee amputation...soft belt while up in wheelchair due to inability to regain trunk control...(for positioning)..."</p> <p>Medical record review of a Physical Restraint Elimination Assessment dated January 10, 2013, revealed, "...D/C (discontinue) soft belt for unsteady gait...soft belt while up in w/c for positioning second to no trunk control..."</p> <p>Medical record review of the quarterly assessment dated March 26, 2013, revealed the resident had severe cognitive impairment, required extensive assistance of two for all Activities of Daily Living, and no restraints were used.</p>	N 424		

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N 424	<p>Continued From page 38</p> <p>Medical record review of the Physician's Recapitulation Orders dated June 1, 2013, through June 30, 2013, revealed, "...soft belt while up in W/C d/t lack of trunk control and weakness..."</p> <p>Review of the manufacturer's application instruction sheet for the lap belt revealed, "...lay the belt across the patient's lap...bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt guard...go around the back post and cross the straps behind the patient...secure the loops on the wheelchair tilt levers...belt should be over the patient's hips at a 45-degree angle holding the hips against the back of the chair..."</p> <p>Observation on June 10, 2013, at 10:40 a.m., in the Wing Two Dining Room, revealed the resident in a wheelchair with a soft belt restraint in place with the ties placed under the axle of the wheel chair.</p> <p>Observation and interview on June 10, 2013, at 10:52 a.m., in the Wing Two Dining Room, with the Director of Nursing, confirmed the facility failed to apply the soft belt restraint for positioning according to manufacturer's recommendations.</p> <p>Observation with the Purchasing Agent June 17, 2013, at 10:18 a.m., in the purchasing department, revealed seven bed pad alarms and four chair pad alarms available for use. Continued observation revealed the alarm pads had a twelve month limited warranty "...warrants this product to be free from factory defects in materials and workmanship for a period of 12 months from the date on the product..." Further review revealed six of seven bed pad alarms greater than one</p>	N 424			

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N 424	<p>Continued From page 39</p> <p>year old and four of four chair pad alarms greater than one year old.</p> <p>Interview with the facility Purchasing Agent June 17, 2013, at 10:24 a.m., revealed the same alarm box (attaches to bed or chair pad alarm) was sent out for chair and bed alarm use. Interview revealed batteries were not installed in the alarm box and only sent out if the alarm was going to be used for chair placement. Interview revealed a power cord was sent out when the alarm was to be used for bed alarm use. Continued interview revealed there was no current system to check function of alarms in use.</p> <p>Telephone interview with the alarm box company President on June 18, 2013, at 2:32 p.m., revealed the alarm box would function if the power cord was not attached if batteries were installed in the alarm box. Continued interview revealed some facility's change out alarm pads after the warranty is out and it depends on the facility policy.</p> <p>Interview with the DON and Assistant Director of Nursing (ADON) on June 18, 2013, at 4:45 p.m., in the DON office, confirmed resident falls with alarm use had not been recently addressed as a Quality Assurance issue. The ADON further confirmed that falls and alarm use was determined as not hooked up correctly or cut off and sometimes was unsure what happened to the alarm.</p> <p>Interview with the Administrator, DON, and ADON on June 18, 2013, at 5:00 p.m., in the DON's office confirmed alarm misuse and falls had occurred on more than one occasion. Continued interview revealed the facility did not have a management plan or policy to check alarm</p>	N 424			

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N 424	Continued From page 40 function or maintenance. In summary, investigation during the annual survey revealed the facility failed to ensure systems were in place to prevent frequent falls of residents resulting from nonfunctioning alarms; from staff not ensuring care planned falls interventions were in place; and from staff not implementing new interventions to prevent further falls when interventions were determined to be ineffective. Review of the facility investigations related to falls revealed the facility had not utilized the data from the investigations to address resident safety concerns (both individually and globally), or to use the data in formulating strategies to ensure resident safety for any residents residing in the facility who determined to be at high risk for falls.	N 424			
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Based on review of the facility Quality Assurance (QA) Committee, facility investigation reviews, facility policy reviews, observations, and interviews, the facility failed to ensure the Quality Assurance Committee identified residents' safety, alarm use and falls as potential areas for quality improvement. The facility's failure to review data and	N 601	Resident # 134, # 37, #58, #71, #95, #111, #52, #193, #2, #18 and #13 1) The DON, Administrator, and Medical Director reviewed and revised the QAPI Plan (J) and presented the Plan (J) at a called meeting on 6/25/13 of the QAPI meeting and developed a standardized Agenda (J) and minute format (J) to ensure all topics and reports are reviewed and addressed on a quarterly basis. The following are members of the QAPI committee: Administrator, DON, ADON, Social Services Director, Business Office Manager, Clinical Managers, Activities Director, Dietary Manager, Rehab Director, Pharmacy Consultant, Maintenance Director, and Medical Director.	07/15/13	

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N 601	<p>Continued From page 41</p> <p>formulate/implement improvement plans placed four resident's (#37, #58, #71, and #134), in an environment which was detrimental to their health, safety, and welfare. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place residents #95, #111, #52, #193, #2, and #18 (of fifty-six residents reviewed) in an environment which was detrimental to their health, safety, and welfare.</p> <p>The findings included:</p> <p>Review of the facility investigations related to falls revealed the facility had not utilized the data from the investigations, to track, trend, and address resident safety concerns (both individually and globally), or to use the data in formulating strategies to ensure resident safety for all residents residing in the facility.</p> <p>Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on June 18, 2013, at 4:45 p.m., in the DON office, confirmed the ADON was over Quality Assurance (QA) and resident falls had not been recently addressed as a Quality Assurance issue. The ADON further confirmed that falls and the issue of alarm use (determined as not hooked up correctly; alarm turned off; no system to monitor functioning) had not been identified for a corrective action plan.</p> <p>Telephone interview with the Medical Director (MD), by telephone on June 18, 2013, at 4:45 p.m., revealed the MD is a QA Committee member and attends weekly meetings. The MD denied remembering any recent trend with falls</p>	N 601	<p>Attachment: QAPI Plan, Trending Reports, and quality indicators.(J)</p> <p>The DON & Administrator developed monitoring tools for Falls, Alarms, and careplans to ensure safety of all residents in facility. The monitoring tools for falls (B) will be completed by the ADON and /or Clinical Managers daily and will be provided to the DON to compile an analysis to present to QAPI. A checklist for falls, skin tears, and bruises was developed for licensed nurses to use to ensure all information is completed at time of fall. Four incident logs were revised into one to ensure tracking and completion of investigation. Fall rosters were developed to aid the Charge Nurses in tracking interventions on each resident. The ADON ensures the section on notification of the physician is always completed on the incident form. The monitoring tools for alarms will be completed by the CNAs daily and will be provided to the DON to compile an analysis to present to QAPI. A copy of the care plan is attached to every fall incident for ADON to review and to ensure that interventions have been added to the care plan.</p> <p>Attachment: Checklists (B), incident log, Alarm checklist (D), Falls intervention roster (K).</p> <p>2) On 6/25/13 the Administrator, with consultation of a Healthcare Consultant, conducted a Department Head meeting to review new QAPI plan, agenda, and monitoring parameters methodology for collecting and analyzing data. On 6/25/13 the Administrator developed Quality Improvement Objectives for 2013 to be presented at the July QAPI committee meeting and the July Board meeting.</p> <p>Attachment: 2013 Objectives (L)</p>		

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N 601	<p>Continued From page 41</p> <p>formulate/implement improvement plans placed four resident's (#37, #58, #71, and #134), in an environment which was detrimental to their health, safety, and welfare. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place residents #95, #111, #52, #193, #2, and #18 (of fifty-six residents reviewed) in an environment which was detrimental to their health, safety, and welfare.</p> <p>The findings included:</p> <p>Review of the facility investigations related to falls revealed the facility had not utilized the data from the investigations, to track, trend, and address resident safety concerns (both individually and globally), or to use the data in formulating strategies to ensure resident safety for all residents residing in the facility.</p> <p>Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on June 18, 2013, at 4:45 p.m., in the DON office, confirmed the ADON was over Quality Assurance (QA) and resident falls had not been recently addressed as a Quality Assurance issue. The ADON further confirmed that falls and the issue of alarm use (determined as not hooked up correctly; alarm turned off; no system to monitor functioning) had not been identified for a corrective action plan.</p> <p>Telephone interview with the Medical Director (MD), by telephone on June 18, 2013, at 4:45 p.m., revealed the MD is a QA Committee member and attends weekly meetings. The MD denied remembering any recent trend with falls</p>	N 601	<p>All staff will report to their respective Department Head to communicate observed problems or concerns.</p> <p>3) Beginning 6/25/13 the Administrator will conduct timely QAPI Committee meetings monthly, and more often if necessary, to ensure the quality of care is monitored and complies with the standard of care.</p> <p>Beginning 6/25/13, the Administrator will ensure the Monitoring and Trending Reports for falls, alarms, careplans, incident reports, Incident/Accidents, Infections Control, Reportable Events and Environment of care, timely processing of physician orders, hand hygiene, food temperature, medication administration, allergy noted, protective coverings during meals, are all completed.</p> <p>4) Beginning 6/25/13, the Administrator will conduct meetings timely, ensure all members attend meetings 100% of the time with any absences approved prior to meeting and that all monitoring tools are completed in a timely manner for each meeting by all respective managers.</p>		

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N 601	Continued From page 42 and alarm use recently discussed.	N 601			
N 613	Refer to N-424 1200-8-6-.06(2)(d)1. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 1. Delineate the responsibilities of and communicate with attending physicians to ensure that each resident receives medical care; This Rule is not met as evidenced by: Based on medical record review, facility policy review, review of manufacturer's instructions, observation, and interview, the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure an effective system for supervision of residents at risk for falls. The facility's failure placed four residents (#134, #37, #58, #71) in an environment which was detrimental to their health, safety and welfare. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place resident #95, #111, #52, #193, #2 and #18 (of fifty- six residents reviewed) in an environment which was detrimental to their health, safety, and	N 613	Resident # 134, # 37, #58, #71, #95, #111, #52, #193, #2, #18 and #13 1. The Medical Director reviewed the treatment plans and falls interventions of each resident on 6/25/13 for effectiveness and any needed changes to their plan of care. This was recorded in the progress note of each resident. Beginning on 6/24/13, the DON, Administrator, and Medical Director reviewed and revised the policies and procedures as follows: Falls Prevention Program with forms and Chair and Bed Alarm. On 6/24/13, the Healthcare Consultant reviewed the Federal and State responsibilities required for the Medical Director with the DON, Administrator, and Medical Director. 2. On 6/25/13, the DON, ADON, Clinical Managers and Staff Development Nurse reviewed the medical records of all residents with falls for the past 45 days to ensure correct interventions were in place. There were new clarified interventions implemented on three residents and put on care plans. PT/OT screened each resident at the time of each fall and evaluations, treatment, or intervention were put into place. The DON reviewed the outcomes of these reviews with the Medical Director. On 6/25/13, the DON, ADON and Clinical Managers assessed all residents with alarms using the new Assessment for Assistive Device. Eleven alarms were removed based on the outcomes of the assessments. Due to resident level of functioning, alarms no longer required and/or no falls within past 90 days. This was reviewed with the Medical Director.	07/15/13	

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STATE FORM

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N 613	<p>Continued From page 43</p> <p>welfare.</p> <p>The findings included:</p> <p>Interview with the Medical Director on June 18, 2013, at 4:45 p.m., by telephone, confirmed the Medical Director was aware of the facility's reported number of incident/accidents with falls. Further interview confirmed the Medical Director had not been aware of any issues identified with falls and/or safety alarms and had not been involved in developing any policy and procedures or systems to ensure residents at risk for falls had effective interventions in place.</p> <p>Refer to N-424 Refer to N-601</p>	N 613	<p>All devices were tested for functionality by ADON, chair and bed alarm policy C) were put into place, assessment of assistive device (E) and alarm check forms (D).</p> <p>On 6/24/13 and 6/25/13, the DON and/or Staff Development Nurse conducted mandatory in-services for all nursing staff concerning revised fall prevention program with changed forms, chair and bed alarm. Any RN, LPN or CNA not attending mandatory in-services will not be allowed to work until they have attended the in-service. All employees will complete a post-test following the in-service within 7 days administered by Staff Development Nurse and/or Clinical Managers.</p> <p>3. Beginning on 6/25/13, the Administrator will monitor Medical Director's attendance at the QAPI committee and that signatures are obtained on the reports submitted for review. On 6/25/13, the DON implemented the monitoring tools approved by the Medical Director and Administrator necessary to monitor alarms, restraints, falls interventions, Notification of Physician of lab results, changing O2 tubing and humidifiers timely, medication administered when allergy present, accurate MDS assessments and careplans, dignity of delivery of trays, placing of clothing protectors, restraints and reporting incidents of unknown origin to State.</p> <p>4. Beginning 6/25/13, the Administrator will conduct meetings timely, ensure all members attend meetings 100% of the time with any absences approved prior to meeting and that all monitoring reports are completed in a timely manner for each meeting by all respective managers. The Administrator will report to the governing body concerning</p>		

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N 613	<p>Continued From page 43</p> <p>welfare.</p> <p>The findings included:</p> <p>Interview with the Medical Director on June 18, 2013, at 4:45 p.m., by telephone, confirmed the Medical Director was aware of the facility's reported number of incident/accidents with falls. Further interview confirmed the Medical Director had not been aware of any issues identified with falls and/or safety alarms and had not been involved in developing any policy and procedures or systems to ensure residents at risk for falls had effective interventions in place.</p> <p>Refer to N-424 Refer to N-601</p>	N 613	<p>these monitoring outcomes on a quarterly basis or more often as necessary.</p> <p>Attachment: Review of all residents to identify any needed additional interventions. List of residents who were assessed and the ones with alarms removed. (N)</p> <p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's creditable allegation of compliance.</p>		